STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER 390326 NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S HOSPITAL - ANDERSON CAMPUS STATE LICENSE NUMBER: 22800101		STREET ADDRESS,	(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING: RESS, CITY, STATE, ZIP CODE: LUKE'S BLVD. , PA 18045		(X3) DATE SURVEY COMPLETED: 07/24/2023		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CX5) COMPLETE DATE		
P 0000	This report is for the n service, telemedicine-t July 24, 2023. The St. Campus attested they the requirements of the Health's Rules and Re Code, Part IV, Subpar 1987, as amended Jun	nderson nce with artment of als, 28 PA	P 0000				
LABORATORY	/ DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

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Certified End Page

ST. LUKE'S HOSPITAL - ANDERSON CAMPUS

STATE LICENSE NUMBER: 22800101 SURVEY EXIT DATE: 07/24/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY